GRIEF AND MOURNING

Article by Michael Durfee, M.D.

If you had attended all meetings of the ICAN Child Death Review Committee since it was established, you would have heard details about the deaths of well over 500 children. Most of them were infants or toddlers. Many were homicide victims. A few died brutally with prolonged intentional assault, burns, scalds, starvation, dehydration, smothering or drowning. Those cases find a place in your mind and maintain a life of their own, refusing to remain archived behind magic barriers.

Some assaults were explosive, unplanned moments in response to minor irritations such as urination or defecation into diapers or training pants. Perhaps more commonly the child was hit, kicked or thrown because of crying, in childish protest of hunger, fear, pain, or being alone. Some deaths were beyond the intent of the perpetrator, if the perpetrator had only controlled violent impulses or had not been left with the care of a child.

Hearing such stories, you share the experiences of the child for the time that can be tolerated. You fly across the room to hit a wall, try to hide, sob, stop breathing from the pain, cry again, promise to be good, and finally sink into a stupor, perhaps hearing words of apology that you may be too young to understand. You may hate your offender who is sexually assaulting your preschool body. You may love the person who generally parented well until that terrible moment.

Death may have come from malice or ignorance. The child may have slowly lost the strength to protest as fever, hunger, dehydration and fatigue took their final toll. A caretaker may have strained to survive in a world of great demands and few resources. Other caretakers may have neglected, abandoned or abused the child while in a chemical stupor.

As you listen to the stories, you become the adult professional caring for the small body, advising surviving family members, arresting the angry, silent or tearful suspect. You wonder about friends, families, neighbors, and previously involved professionals suffering with repeated self-doubt and criticism.

You might wonder about a parent sitting in a cell reliving that moment, wondering how they came to be there, trying to bargain with their Maker or cause time to reverse.

With great discomfort, you may be the sibling, hiding to avoid a similar assault, or smiling to avoid abuse, or trying to forget.

How can people hear such terror, pain, isolation, betrayal, perversion of the guardian role or caretaker to a child? Why would people choose to hear such misery?

The team of individuals from varied professions makes such work manageable with candor and moments of shared self re-examination. The team protects such candor,

struggles to protect members from undue damage, and occasionally speaks critically as members back off from the responsibility that all must share. Sooner or later, we must ask, “What can we do for those children who will die tomorrow, next month, or next year?”

Reliving the deaths of hundreds of children changes you. Babies become small people with real needs and rights generally saved for adults. Playgrounds and small voices laughing are more precious. An adult sharing a mutual gaze of affectionate fascination with a baby becomes a great work of art. The grass of a graveyard becomes a blanket that protects still little bodies that cannot be forgotten. Reviewing these deaths is not a burden. It is a responsibility and a privilege.

THE STORY OF MIKEY

Five-year-old Jennifer saw her infant brother Mikey beaten by her mother’s boyfriend the previous night. They had shared a bedroom and it was quiet until late morning when their mother entered and began to scream. Jennifer was left with her grandmother after the police and ambulance arrived.

Several weeks later the body had been released and buried with three adults as the only witnesses. No one spoke to Jennifer about the death except to reassure her that it will be OK. The exception was a uniformed police officer that tried to ask her what she had seen. A half sibling in another state is never told of the death.

Jennifer’s school teacher now knows about the death but doesn’t know how to find the case worker or the grave and doesn’t know if she should talk to the mother that used to visit Jennifer at school. All of the school staff talks about the case but only the teacher talks to Jennifer who has generally withdrawn except for episodes of hitting others or kicking dolls.

No one speaks to the 12 year old babysitter who held Mikey, and is now wondering what it will be like for her when she becomes a mother. Her parents note that it is good that she never has to go there again.

No one speaks to the paramedic and medical staff who tried to keep the battered infant alive. The ambulance hurried away from the hospital minutes after leaving their small victim. The cold blue infant body was eventually described as dead on arrival although hospital staff had continued intervention until a new resident had arrived to pronounce the baby officially dead.

Jennifer’s mother and grandmother speak occasionally, mostly to argue about the mother’s parenting and choice of men and the failure of the grandmother or other family members to help when Jennifer’s mother had been beaten by her boyfriend.

Law enforcement and jail staff had conversed as necessary, mostly to find a confession. The boyfriend told law enforcement how the baby made him mad, and that he didn’t mean to kill Mikey. His family later told him to stay away. He moved in with an old girlfriend who had children. She loved him, and told herself that this time it would be

different for her.

The homicide detective had no training in child abuse. The pictures of the dead baby were seen by many of his fellow officers and some of the clerical staff. One officer went home during the day to check on his new infant son. High levels of energy the day of the arrest were followed by a strange quiet the following day.

The medical examiner who did the autopsy was a professional and an autopsy was an autopsy. He did find himself sleeping poorly, and he drank a little more than usual, and seemed to have trouble getting his report done.

Preparation of the body at the funeral home had been problematic. It was hard to cover all the bruises, and the technician found herself crying for the first time in her career. The minister did well at the services, but seemed irritable for some months after. He repeatedly assured his wife, who hadn't asked, that of course there is a God.

The District Attorney did not prosecute the case. At home, the prosecutor talked about the pictures and her anger with her work, until her husband physically avoided her.

A reporter, who covered the death, got angry with her editor, who finally put the story in the paper as a single paragraph. The paper had just covered a notorious child homicide in another county, and the editor was concerned about too many stories on the same topic. Some people who read the story included an old man, who wondered again what had happened to his baby sister who had suddenly died when he was seven.

A mental health worker had two interviews with Jennifer, as part of the six months of court ordered intervention, before the case was closed. The mother finished most of the court ordered parenting. The class on adolescence had confused her. The short session on diapers and babies had made her sad. She hoped that no one had noticed her tears or the fact that she was pregnant again.

A mental health counselor missed several comments Jennifer made about the worms come eat you. The mother stated that she had the right to keep Jennifer away from the funeral, although she was not sure if she had made the right decision.

Several hundred people felt the loss of this generally unnamed baby. Jennifer became known as the girl who had the murdered baby brother. Case records were closed. The major follow-up was a departmental investigation of another protective service worker who had seen the mother and Jennifer at a shelter before Mikey was born. Questions about that contact were generally handled by senior staff and an attorney, to make sure that there was no liability. Two workers now knew the family but never spoke to each other about the case.

The grave became noticed by an elderly woman. The new stone sat on a small wedge of grass next to her deceased husband's grave. She kept the grave clean for a while and even brought flowers. Jennifer, her mother, the boyfriend and those close to them will be affected by the death for all of their lives. Some will pass anger and fear on to new generations.

GUIDELINES FOR INTERVENTION WITH SURVIVORS OF FATAL/SEVERE FAMILY VIOLENCE

Death or permanent injury of a family member is not just another psychological issue. Psychotherapy, funerals, grave visitation, memory books, family gatherings, and rituals for anniversaries must all be considered. Infants and toddlers and uninvolved siblings have issues. Grief intervention is more than brief psychotherapy. The best intervention for some children and families may involve support for rituals and no therapy or vice versa.

- Locate protocols and programs in your agency now, before you need them.
- Read about this process. Try bookstores or special bibliographies.
- Mourning is a natural process not necessarily an illness to be fixed.
- An overwhelmed survivor is not automatically mentally ill.
- Take your lead from the survivors. Listen for nonverbal cues.
- The developmental stage of the child is critical. (Know human development)
- Consider the entire family. (i.e. friends, neighbors and line staff)
- Respect the culture and religion of the child and family.
- Don't censure pain with reassurances. Respect the sense of loss.
- Provide simple, honest explanations when asked.
- Ask for help with your own pain. Don't hide it and don't impose it.
- Let the child and family contact you in the future. Consider calling or writing them.

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